BP CORPORATION NORTH AMERICA INC.
LIFE AND ACCIDENT PLAN

(As amended and restated as a Component Benefit Program of the
BP Corporation North America Consolidated Welfare Benefit Plan effective April 1, 2011)

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ARTICLE I
INTRODUCTION

1.1 ***Purpose of the Plan***: The purpose of the Plan is to provide life and accident insurance Benefits to Plan Participants and/or their Beneficiaries and, in furtherance thereof, to set forth the provisions for the administration and operation of those Benefits. This Plan and its accompanying exhibits, along with the BP Welfare Plan document, will be the sole documents used in determining Plan Benefits for which Participants may be eligible, and these documents may be amended or terminated at any time in accordance with the procedures listed herein. Any amendment or termination so made shall be binding on all persons affected by such.

1.2 ***Status of the Plan***: The Plan is a "Benefit Program" under the BP Welfare Plan, as amended from time to time; accordingly, administration of this Plan is also subject to the relevant provisions of the BP Welfare Plan. In the event that any provision or implication in this Plan document conflicts with, contradicts or renders ambiguous a provision or implication in the BP Welfare Plan document, such provision or implication in the BP Welfare Plan shall control, subject to the Plan Administrator's sole discretion. This Plan is intended to qualify as an "employee welfare benefit plan" under ERISA, but is not intended to qualify as a "medical care plan" under the Internal Revenue Code, nor as a group health plan, defined in either ERISA, the Family and Medical Leave Act of 1993 ("FMLA") or the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Except to the extent provided herein, nothing herein shall be construed to affect the provisions of any other benefit plan maintained by the Participating Employers.

1.3 ***Scope of the Plan and Relationship to the Insurance Contract***: The Plan may be funded by Insurance Contracts, Trusts, Participant contributions, the general assets of the Company or any combination thereof. If any Plan Benefits are provided through Insurance Contracts, details regarding coverage, Benefits and claims under those provisions of the Plan shall be as described in the applicable Insurance Contract. Should eligibility provisions contained in the Summary Plan Description conflict with the terms of an applicable Insurance Contract, such eligibility terms in the Summary Plan Description shall control. If Insurance Contracts are used to fund Benefits herein, such Insurance Contracts will be included as exhibits to this Plan document, thereby forming a part of this Plan document for all purposes, and no Benefits shall be payable through such Insurance Contracts unless the Insurer reasonably determines the claimant is entitled to them, subject to the other terms as stated herein. Notwithstanding the above, on no account shall a separate bank account, if any, established by a Participating Employer to fund its Plan obligations be considered owned by or an asset of the Plan, nor shall such fund be considered a Trust, unless a Trust Agreement is entered into by the Company assigning both such designations thereto.

1.4 ***Applicable Laws***: The Company intends this Plan to comply with all applicable laws and their regulations, as amended. To the extent that any provision in this Plan must be interpreted or construed, the Plan Administrator and/or the Insurer, as applicable, shall have the authority, both jointly and severally, to exercise such discretion in both a non-arbitrary and non-capricious manner, and the Plan shall be interpreted or construed in such a manner as is necessary for the Plan to be in compliance with all applicable laws.

ARTICLE II
DEFINITIONS

2.1 ***Definitions***: Words used in this Plan in the singular shall include the plural and in the plural the singular, and the gender of words used shall be construed to include whichever may be appropriate under any particular circumstances of the masculine, feminine or neuter genders. Unless otherwise defined below, the capitalized terms used herein that are defined in Article II (Definitions and Construction) of the BP Welfare Plan shall have the same meaning as provided therein. The following additional terms shall have the following meanings, unless a different meaning is clearly required by the context:

Beneficiary means any person entitled to receive Benefits from the Plan in accordance with the terms of the Insurance Contracts.

Benefits mean the amounts payable under the terms of this Plan document and/or Summary Plan Description (as may be limited or further described in an Insurance Contract applicable hereto).

BP Welfare Plan means the BP Corporation North America, Inc. Health and Welfare Benefits Plan, as currently in effect or as hereafter amended.

Coverage Option means the life and accidental death and dismemberment coverage options listed in the Summary Plan Description, if any.

Insurance Contract means only those Insurance Contracts, as defined in the BP Welfare Plan, which have been purchased by the Company to provide some or all of the Benefits hereunder. A copy of the current Insurance Contracts shall be attached hereto as an appendix, and such appendix shall be considered updated concurrently with any changes to such Insurance Contracts.

Plan means the BP Corporation North America, Inc. Life and Accident Plan as set forth herein and as may be hereafter amended from time to time.

Summary Plan Description means this Plan's summary plan description, which may or may not be combined with the summary plan description of other Company plans, as it currently exists or is hereafter amended. A copy of the current Summary Plan Description shall be attached hereto as an appendix, and such appendix shall be considered updated concurrently with any changes to such Summary Plan Description.

Trust means the account(s) created by any Trust Agreement(s) established by the Plan Administrator and/or the Company on behalf of the Plan.

Trust Agreement(s) means the written document(s) entered into by the Company or the Plan, if any, to establish a Trust.

ARTICLE III
ELIGIBILITY

3.1 ***Eligibility***: The Plan Administrator, in its discretion and consistent with the requirements of applicable law, has the authority to extend eligibility in this Plan and/or each its Benefit Programs to Employees and other individuals who either have or had an employment relationship with the Company, as well as to their Eligible Dependents. The Plan Administrator may from time to time establish eligibility requirements for such persons as the Plan Administrator may deem appropriate in its sole discretion, and such requirements shall be incorporated into the Plan's Summary Plan Description. Eligibility for Benefits shall terminate consistent with such requirements or other termination of coverage caused either through termination or amendment of the Plan or as of the date an Employee's Participating Employer no longer participates in the Plan. In addition, no eligibility provisions in any Insurance Contracts which are inconsistent with the terms of the Summary Plan Description shall be effective for this Plan unless the Plan Administrator, in its sole discretion, determines otherwise.

3.2 ***Additional Eligibility***: If an individual has entered into a contractual relationship with a Participating Employer whereby such individual and his Eligible Dependents may continue participation in the Plan after an employment relationship has terminated, other than as described herein or in the Summary Plan Description, coverage shall be extended only to such individuals and Eligible Dependents as described in such contract and approved by the Plan Administrator. No other provision of the Plan and the BP Welfare Plan shall be altered in any way by such relationship including, but not limited to, the right to amend and/or terminate this Plan and the BP Welfare Plan.

3.3 ***Eligibility Subject to Discretion***: Notwithstanding anything contained herein, simply because the Company and/or the Plan Administrator has the authority to extend Plan eligibility to certain individuals shall not be considered a requirement to so extend eligibility, and all eligibility provisions of the Plan shall be subject to the amendment and termination provisions stated elsewhere herein.

3.4 ***Participant Contributions***: The amount and frequency of contributions required from a Participant in order to participate in the Plan, if any, shall be determined by the Plan Administrator and shall be communicated to Participants in a manner which complies with applicable law. Further, the amount and/or frequency of Participants' contributions shall be subject to change by and in the sole discretion of the Plan Administrator, and Participants shall be advised of any such change in the time and manner required by applicable law.

ARTICLE IV
LIFE AND ACCIDENT BENEFITS

4.1 ***Amount and Type of Benefits***: The only Benefits provided under this Plan are those described in the Insurance Contracts and/or the Summary Plan Description, and a Participant shall be eligible for such Benefits subject to such conditions as are provided in the Insurance Contracts or Summary Plan Description, as applicable, or, where inconsistent, as provided for herein. The terms and conditions of each Coverage Option shall be described in the Insurance Contract and/or Summary Plan Description applicable to such Coverage Option, or otherwise communicated to Participants in compliance with applicable law, and Benefits offered to each Participant shall depend on the Coverage Option selected by or for that Participant. There shall be no requirement on any Participating Employer, Insurer or any other entity that all Coverage Options be offered to all Participants.

4.2 ***Presenting Claims for Benefits***: Any person claiming Benefits under this Plan shall make such claim in accordance with the provisions of the Summary Plan Description and/or Insurance Contracts, and all such claims shall be subject to, and processed by the Administrative Services Provider, Plan Administrator or Insurer, as applicable, in accordance therewith. All claims procedures adopted by the Plan Administrator, Administrative Services Provider and Insurer shall be compliant with applicable law.

(a) Each Coverage Option may have different requirements for filing claims and appealing denials of claims. All such requirements shall be included in the Summary Plan Description or otherwise communicated to Participants in accordance with applicable law.

(b) Participants may file claims and appeal adverse claim decisions either themselves or through an authorized representative. An "authorized representative" shall mean a person the Participant authorizes, in writing to the Plan, to act on the Participant's behalf. The Plan will also recognize a court order giving a person authority to submit claims on the Participant's behalf.

(c) If the Participant's claims and/or appeals are denied in whole or in part, a written notice of the denial shall be sent to the Participant, which notice must comply with applicable law.

(d) A reduction or termination of a right to receive Benefits will be treated as a claim denial, to the extent required by applicable law.

4.3 ***Administrator Authority to Make Final Binding Decisions***: The Plan Administrator shall administer the Plan in accordance with its terms. The Plan Administrator shall have discretionary authority to the maximum extent allowed by applicable law to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for Benefits, to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan (including the right to remedy possible ambiguities, inconsistencies or omissions). The decisions of the Plan Administrator will be final and binding on all interested parties. While the Plan Administrator has full discretion and authority to finally grant or deny Benefits under the Plan, the Company and the Plan Administrator may, and hereby do, delegate such fiduciary authority to an Administrative Services Provider and/or an Insurer who administers Plan claims to make binding decisions regarding claims for Benefits and the appeals of such claims. As such, the determination of the applicable Administrative Services Provider and/or Insurer on appeal will be final and binding, and such entity shall be considered a fiduciary of the Plan when rendering such decisions. Notwithstanding anything else contained herein, no entity other than the Company and/or the Plan Administrator may act to expand the Benefits or classes of eligibility described herein or in the Summary Plan Description.

4.4 ***Payment of Benefits***: Any Benefit payment made by the Plan in accordance with the Plan's provisions shall fully discharge the Plan, the Company, any Participating Employer, the Insurer, the Plan Administrator and any other Plan fiduciary to the extent of such payment.

4.5 ***Incapacitated Participants***: If the Plan Administrator, Administrative Services Provider and/or Insurer, as applicable, determines that any Participant is legally incapable of giving a valid receipt for any payment due to him, and no guardian for this individual has been appointed, such payment may be made to the individual or individuals who, in the professional judgment of the applicable claims processor, has assumed the care and principal support of the incapable Participant, and any payment made by the Plan in accordance with this provision shall fully discharge the Participating Employers, the Plan, the Plan Administrator, the Insurer(s) and/or the Administrative Services Provider(s), all as may be applicable, from liability to the extent of such payment.

4.6 ***Right to Receive and Release Necessary Information***: The Plan, the Plan Administrator, Administrative Services Provider, an Insurer, a Participating Employer and/or their designees have the right to obtain, receive and release all information in order to administer the Benefits. As a precondition to receiving Benefits, an individual claiming Benefits hereunder (or their Beneficiary, if applicable) is required to furnish to the Plan, the applicable Administrative Services Provider, the Plan Administrator and the Insurer, and/or their designees all information such designees may deem necessary, in their discretion, for the proper administration of the Plan, which includes but is not limited to, all information regarding the medical condition of the Participant for which Benefits are to be, are being or have been paid.

4.7 ***Right of Recovery***: If Benefit payments have been made by the Plan (including, but not limited to, payments made by an Insurer) in excess of the maximum amount payable under the terms of the Plan, the Plan's designated representative (including, but not limited to, the applicable Insurer) has the right to recover the excess amount paid on behalf of the Plan or themselves, as applicable. The Plan shall have the right to recover the excess Benefit payments from any entity in possession thereof. If any entities shall fail or refuse to return any overpayments to the Plan, the Plan and/or Insurer shall have a right to initiate legal action in whatever form against such entities, terminate all eligibility to future Benefit payments otherwise payable to such entities from the Plan from either the same or subsequent claims, and/or offset all future Benefit payments otherwise payable to such entities from the Plan from either the same or subsequent claim until the amount of overpayment is recovered.

4.8 ***Disclosure of Medical Records***: By electing coverage under this Plan, the Plan and its designated representatives (including, but not limited to, the applicable Insurer) may receive and disclose a Participant's medical information in connection with the payment of Benefits and the operation of this Plan. Election of coverage under the Plan will constitute the Participant's consent to the Plan's use of records for this purpose.

4.9 ***Conversion Policy***: If a conversion policy is made available from an Insurer, upon election of coverage under such policy, the Insurer will be the sole provider of the benefits provided to the Participant. Benefits provided under a conversion policy shall not be Benefits, as defined herein, and shall not be an obligation of the Plan or any Participating Employers.

ARTICLE V
ADMINISTRATION AND FUNDING

5.1 ***Plan Administration***: Administration of the Plan shall be subject to Article VI (Administration of the Plan) of the BP Welfare Plan, as amended from time to time, as if fully set forth herein. Each Administrative Services Provider or Insurer, with the general approval of the Company or the Plan Administrator by way of contract or other written instruction, may also establish procedures for the filing and administration of claims under the Coverage Options for which they either provide administrative services, and which procedures shall be set forth in the Plan's Summary Plan Description or otherwise communicated to Participants. All such procedures shall be consistent with applicable federal law and set forth in the Summary Plan Description or otherwise communicated to Participants in accordance with applicable law.

5.2 ***Plan Funding***: The funding policy of the Plan shall be as described in Article V (Funding of the Plan) of the BP Welfare Plan, as amended from time to time, as if fully set forth herein.

5.3 ***Amendment and Termination***: Procedures for amendment and termination of the Plan shall be subject to Article VII (Amendment and Termination of the Plan) of the BP Welfare Plan, as amended from time to time, as if fully set forth herein. Amendments to the Benefits provided hereunder may be accomplished through an amendment to the Summary Plan Description, contract between the Company (or Plan Administrator) and the Insurer, and/or the issuance of either an amendment to or a new Insurance Contract. Notice of a Plan amendment shall be communicated to Participants in compliance with applicable law.

5.4 ***Effect of Amendment or Termination***: If the Plan is amended or terminated, each Participant and their Beneficiaries shall have no further rights under the prior version of the amended or terminated Plan provisions, and the Company, Plan Administrator, Insurers and Participating Employers shall have no further obligations under such prior provisions, except as otherwise provided under the amended terms of the Plan and/or the Insurance Contracts, as applicable. However, no amendment or termination shall be made that would diminish any accrued Benefits arising from incurred but unpaid claims of Participants and/or Beneficiaries existing prior to the effective date of such amendment or termination. Furthermore, if a Participating Employer no longer participates in the Plan, such employer may still be responsible, in the sole discretion of the Plan Administrator, to fund any and all Benefits incurred by its affiliated Participants both prior to and after such termination of such employer's participation in the Plan, as well as any reasonable expenses incurred by the Plan Administrator and/or the Company in accomplishing the Participating Employer's withdrawal of participation.

5.5 ***Information from a Participating Employer***: The Participating Employers shall supply full and timely information to the Company, the Plan Administrator, Administrative Services Providers and Insurers, as applicable, of all matters relating to the employment of its Employees, or any other information in its possession, for purposes of determining eligibility for Benefits, and such other pertinent facts as the Company, Plan Administrator, Administrative Services Providers or Insurers may require.

5.6 ***Effect of Oral or Written Statements***: Any oral or written representations made by an employee or representative of the Company, an Administrative Services Provider, an Insurer, the Plan Administrator or any other individual or entity that alter, modify, amend, or are inconsistent with the written terms of the Plan shall be invalid and unenforceable and may not be relied upon by any Employee, Beneficiary, Eligible Dependent, service provider, or other individual or entity, unless such representation meets the requirements of an amendment or termination of the Plan pursuant to Article VII (Amendment and Termination of the Plan) of the BP Welfare Plan.

ARTICLE VI
MISCELLANEOUS PROVISIONS

6.1 ***Miscellaneous Provisions***: The Plan shall be subject to Article X (Miscellaneous Provisions) of the BP Welfare Plan, as amended from time to time, as if fully set forth herein.

6.2 ***Other Salary-Related Plans***: It is intended that any salary-related benefit plans that are maintained or Companyed by the Participating Employers shall not be affected by this Plan. Any contributions or benefits under such other plans with respect to a Participant shall, to the extent permitted by law and applicable plan documents, be based on the Participant's salary or compensation without regard to any Benefits paid or available under this Plan.

6.3 ***Abuse of Coverage***: In the event that the Plan Administrator makes a good faith determination, in its sole discretion, that evidence exists that a Participant is attempting to abuse Plan coverage or Benefits by attempting or aiding the filing of claims to which a Participant is not entitled, the Plan Administrator may limit or terminate the coverage or Benefits provided to said Participant to the extent it deems necessary to prevent such abuse, and shall be entitled to turn over all information to appropriate governmental authorities to investigate whether fraud has taken place under federal and/or state law. Any such termination or limitation of coverage or Benefits shall be effective at 11:59 p.m. on the date that the Plan Administrator or its designee mails or otherwise provides written notice of same to the Participant. Coverage or Benefits limited or terminated pursuant to this Section may not be reinstated. Notwithstanding the above, neither this Section or any provision of this Plan shall be used in any way to discriminate against any Participant or Beneficiary in the valid exercise of his rights hereunder, including, but not limited to, the election of coverage and the claiming of Benefits to which the Participant is entitled under the terms of the Plan.

6.4 ***Preemption of State Law.*** If any provision of an Insurance Contract or Summary Plan Description purports to allow a state statute or regulation to govern the administration or provision of Benefits provided by this Plan, such provision shall be invalid unless the Plan Administrator, in its sole discretion, determines otherwise. The mere acceptance of an Insurance Contract to fund, in whole or in part, the Benefits provided by this Plan shall not be considered an affirmative act of the Plan Administrator to so determine.

6.5 ***Confidentiality of Personal Information.*** The Participating Employers, Administrative Services Providers, Insurers and Plan Administrator shall comply with all applicable laws relating to the confidentiality and security of personal information relating to Participants and Beneficiaries. However, this Plan shall not be considered a "group health plan", as defined by ERISA and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and shall not be subject to regulation as such, nor shall this Plan be subject to Article IX (Access to Protected Health Information) of the BP Welfare Plan.

6.6 ***Legal Proceedings.*** No action at law or in equity shall be brought to recover on the Plan prior to the expiration of the Plan's claims and review procedures set out in the Summary Plan Description. At such a point and not before, Participants will be considered to have exhausted all administrative remedies. No such legal action shall be valid if brought more than 3 years from the expiration of the time within which proof of loss is initially required by the Plan, or such longer period only if specifically allowed by an applicable federal statute. In addition, the only proper venue for any person to bring a suit to recover benefits shall be in Harris County, Texas.

6.7 ***Discretion to Interpret Plan.*** For the Benefits funded by Insurance Contracts, the applicable Insurer shall have the sole discretion and authority to construe and interpret any and all terms of such Insurance Contracts, including but not limited to the discretion to resolve ambiguities, inconsistencies or omissions conclusively; provided, however, that all such discretionary interpretations and decisions shall be applied in a uniform and nondiscriminatory manner to all similarly situated Participants. Should any Benefits be funded by other than an Insurance Contract, the Plan Administrator

shall have identical authority regarding such Benefits. Decisions by the applicable Insurer regarding Benefits funded by Insurance Contracts, and by the Plan Administrator regarding Benefits funded by any other method, shall be binding and conclusive upon all persons.

APPENDIX A
SUMMARY PLAN DESCRIPTION

BP group universal life (GUL) insurance program

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Group Universal Life (GUL) Insurance Program

GUL is available in addition to company-provided basic life and AD&D insurance

In addition to your company-provided basic life and accidental death and dismemberment coverage, BP's Group Universal Life (GUL) Insurance Program offers you the opportunity to elect additional life insurance for yourself, your spouse/domestic partner and your eligible children. This option gives you flexibility as you plan for your family's future financial needs.

The GUL Program is insured and administered by MetLife and:

- Provides life insurance coverage at group rates; and
- Gives you the chance to build cash value through the program's Cash Accumulation Fund.

If you enroll in GUL coverage, and if you die while covered, the GUL benefit will be paid in addition to any benefit paid under the Basic Life/AD&D Insurance Plan and/or the Occupational Accidental Death (OAD) Plan.

Because this document is intended as a summary of a BP benefits plan, it is not intended to describe each plan provision in full detail. More complete details are contained in the governing plan documents (including applicable insurance policies). While we intend to update this summary on a regular basis, it is possible that at any point this summary may be neither current nor complete. Further, differences between this summary and the applicable plan document are not intended. If, however, any differences are found to exist, the relevant provisions of the applicable plan document — and not the summary — will govern.

BP reserves the right to amend or terminate a plan at any time without advance notice.

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Eligibility and participation

Learn about the eligibility rules governing the Group Universal Life Plan

Who is eligible

You may elect coverage under the Group Universal Life (GUL) Insurance program if you are classified as a full-time or part-time employee of a participating employer.

Full-time employee: An employee assigned to a position that:

- Requires full-time service as determined by BP;
- Is established to fill regular and ordinary employment requirements; and
- Is expected to continue for an indefinite period of time.

Part-time employee: An employee assigned to a position that is:

- Regular and ordinary in nature;
- Expected to continue for an indefinite period of time; and
- One in which the employee works a schedule that is less than that of a full-time employee but is at least 20 hours a week.

Eligible dependents

You may also elect coverage for your eligible dependents, including your:

- Spouse, including your legally separated spouse.
- Common-law spouse (if you and your common-law spouse reside in a state that recognizes your common-law marriage as a legal marriage).
- Domestic partner of the same or opposite sex. (GUL coverage cannot be offered to domestic partners in some states due to state regulations.)
- Eligible dependent child(ren). You or your spouse/domestic partner must elect GUL coverage in order to elect coverage for your eligible child(ren).

An "eligible dependent child" is a dependent child from age 14 days up to 26* years who is:

- Supported solely by you and permanently living in the home of which you are the head;
- Legally adopted; or
- A stepchild who lives in your home.

Regardless of whether your dependent child meets the conditions above, he/she may not be covered if he/she is:

- In the military of life forces of any country or any subdivision of a country; or
- Eligible under this plan as an employee.

* A child age 19 or over who works full time is not eligible. Any child covered under the GUL program who is totally and permanently disabled at the time he/she turns age 26 can continue to be covered after age 26. If this applies, you must contact MetLife to request a form documenting disability. The form must be completed, signed by the treating physician, returned to MetLife and approved before coverage will continue.

If both you and your spouse work for BP, you have two enrollment options:

- You and your spouse may each enroll as an employee; or
- One of you may waive coverage and enroll as a dependent under the other spouse's coverage.

Domestic partners

There are two alternative methods for qualifying your same-sex or opposite-sex domestic partner as an "eligible dependent":

- Alternative "A": Register your domestic partnership or civil union in accordance with registration requirements in the state in which you and your domestic partner or civil union partner reside. Your registration date is the first date you can enroll your partner as a domestic partner under the plan; or
- Alternative "B": Satisfy each of the following requirements for at least six full months before signing a Domestic Partner Affidavit. The date you are first eligible to sign the affidavit is the date your partner will be considered your domestic partner for plan purposes.
    - Be each other's sole domestic partner and intend to remain so indefinitely.
    - Reside together in the same principal residence and intend to remain so indefinitely;
    - Be emotionally committed to one another, share joint responsibilities for the partnership's common welfare and be financially interdependent;
    - Be at least 18 years old, of legal age and mentally competent to enter into contracts;
    - Not be related by blood closer than would bar marriage under applicable law where you live; and
    - Not be legally married to, nor the domestic partner of, anyone else.

Note: Under the plan, and pursuant to federal law, a civil union and a same-sex marriage must be treated the same as a domestic partnership.

Your domestic partner will cease being an eligible dependent as of the date you cease to satisfy any of the above conditions. If your domestic partnership ends, call the BP HR & Benefits Center immediately.

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Who is not eligible

Regardless of your employee classification, you are not eligible to participate in the Group Universal Life (GUL) Insurance Program if you are:

- An occasional employee.
- A temporary employee.
- A member of a collective bargaining unit (union), unless your collective bargaining agreement provides that you are eligible to participate.
- Not classified as an employee on a participating employer's payroll, even if reclassified as a common-law employee by any third party.
- An Inpat (foreign resident working in the U.S.).
- An employee on an unpaid leave of absence which has not been approved by BP.

Note that if an employee is not eligible, the employee's family members are also not eligible.

Occasional employee: For purposes of the plan, an "occasional employee" means an employee who is employed by BP for work that is irregular or infrequent in nature and which ordinarily should last no longer than four to six months, or an employee who works a regular schedule that is less than 20 hours per week and which is expected to continue for an indefinite period of time.

Temporary employee: An employee assigned to a position that:

- Requires full-time or part-time (not occasional) service as determined by BP;
- Requires a regular schedule of hours; and
- Will continue for a specified period of time or until the occurrence of a specified event, such as the return to work of a regular employee or the completion of a special assignment or project.

Interns and co-ops are considered occasional employees.

An employee's classification in BP's payroll records controls eligibility regardless of whether the individual is later reclassified. An employee's classification is determined at the time of hire. If later changed, the new classification will only apply prospectively, regardless of the actual hours worked under the initial classification.

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How to enroll

As an eligible employee, you can enroll through the BP HR & Benefits Center via LifeBenefits at http://www.bp.com/lifebenefits or by calling the BP HR & Benefits Center:

- Within the U.S.: 1-800-890-4100
- Outside the U.S.: +1-312-843-5290

You may have to provide evidence of insurability, depending on the coverage level you request or if you do not enroll within 30 days of the date your enrollment kit was mailed. If you enroll online, you will be able to fill out the evidence of insurability online. See Evidence of insurability for details.

You should contact the BP HR & Benefits Center for answers or assistance with the GUL Program.

All coverage under the GUL Program is based on the truthfulness of statements made by you and your dependents. Coverage may be terminated, including retroactively, if such statements are found to be false, and intentional falsehoods will be considered a violation of the BP Code of Conduct, subjecting you to disciplinary actions, up to and including termination of employment.

Note: From time to time, **special opportunities to increase the amount of GUL coverage** for yourself and/or your spouse/domestic partner may be available during Annual Enrollment if you meet certain criteria. Evidence of insurability may or may not be required for such opportunities. Details will be announced in your Annual Enrollment materials.

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Paying for coverage

You pay the entire cost of GUL coverage through payroll deductions on an after-tax basis. Deductions begin as soon as administratively possible. Deductions are taken retroactively to the effective date of your coverage. If your pay is not sufficient to take deductions for contributions (for example, if you are on unpaid leave of absence) you will be billed directly by MetLife.

The cost of coverage for you and your spouse/domestic partner will be based on:

- Your age.
- Your spouse's/domestic partner's age.
- The level of coverage you elect.
- Whether you and/or your spouse/domestic partner uses tobacco products.

The GUL Program offers discounted rates to those who do not use tobacco products. Tobacco products include snuff, chewing tobacco, pipes, cigars and cigarettes. Use of any tobacco products at any time during the 12 months before enrollment constitutes tobacco use. If you do not indicate your "tobacco user" status on the enrollment form you submit to MetLife, the application is considered incomplete. The enrollment will not be processed until MetLife receives an appropriate response.

Calculating your cost

If you wish to purchase GUL coverage, take these steps to calculate the monthly cost:

- **Step 1:** If your current base pay is not an even multiple of $1,000, round the amount up to the next thousand. (For example, $34,200 would be rounded up to $35,000.) Determine the increment of base pay you wish to cover (such as two times base pay). Multiply your base pay by this number to calculate the total amount of coverage you want. (For example, two times $35,000 would equal a coverage amount of $70,000.)
- **Step 2:** Divide the coverage amount by $1,000.
- **Step 3:** Multiply that number by the monthly rate from the table below. Rates are also included in your new-hire packet and are available on the LifeBenefits online site.

The following rates apply to active employees effective April 1, 2015. Rates for retired employees, and for former employees not eligible for retiree medical coverage, who choose to continue GUL coverage are different.

If your or your spouse/domestic partner's age is ...	**Monthly rate per $1,000 is ...**	
	Non-tobacco user	**Tobacco user**
Under 25	$ .028	$ .036
25 – 29	$ .032	$ .038
30 – 34	$ .032	$ .039
35 – 39	$ .032	$ .040
40 – 44	$ .062	$ .081
45 – 49	$ .099	$ .127
50 – 54	$ .159	$ .204
55 – 59	$ .253	$ .324
60 – 64	$ .436	$ .553
65 – 69	$ .669	$ .869
70 and older	Call MetLife at 1-800-GET-MET-8 (1-800-438-6388)	
The cost of child coverage is $1.00 per month, regardless of the number of children you choose to cover.		

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When coverage begins

Your coverage begins on the first of the month following MetLife's approval of your application. You must be actively at work at BP on the effective date for coverage to begin. If you are not actively at work on that date, coverage begins the first of the month following the date you return to work at BP.

Coverage for your eligible dependents begins the same day your coverage begins, as long as they:

- Have not been hospitalized during the previous 90 days or on the enrollment date.
- Are not confined at home for any medical reason on the effective date of coverage.
- Are not receiving or entitled to receive disability income for any medical reason on the effective date of coverage.

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When you can change coverage

You can make changes to your GUL coverage at any time by logging on to the BP HR & Benefits Center via LifeBenefits at http://www.bp.com/lifebenefits or by calling the BP HR & Benefits Center:

- Within the U.S.: 1-800-890-4100
- Outside the U.S.: +1-847-883-0469

You may be required to provide evidence of insurability acceptable to MetLife before an increase in coverage takes effect.

After the BP HR & Benefits Center receives your completed change request, the change will be made as soon as administratively possible. You must be actively at work on the date an increase in coverage is to take effect. If you are not actively at work on this date, the change takes effect on the first of the month following the date you return to work.

If you have elected eligible dependent GUL coverage and no longer have any eligible dependents, you should contact the BP HR & Benefits Center to drop this coverage. NOTE: A dependent child who is no longer eligible may convert his/her coverage to an individual policy. A spouse/domestic partner who is no longer eligible may port his/her coverage. See Continuing Coverage for more information.

Qualifying status changes

Certain life events are considered qualifying status changes. Within 30 days of one of these life events, you may elect GUL coverage equal to one times your base pay, or you may increase your GUL coverage by one times your base pay, without having to provide evidence of insurability as long as the covered participant has not been hospitalized 90 days before this change and has not been declined previously. These qualifying status changes include:

- Marriage or establishment of a domestic partnership.
- Birth, adoption or placement for adoption of a child.
- Divorce, annulment or the end of a domestic partnership.

For more information about these changes, call the BP HR & Benefits Center.

Publication date: April 2017

When coverage ends

GUL coverage ends on the earliest of the following:

- The date you reach age 100.
- The date you fail to make a required payment in a timely manner.
- The date you surrender coverage.
- The date the death benefit is payable.
- On the date through which your premiums are paid, when you terminate employment.
- The date BP terminates the GUL Program.
- The date you begin an unpaid leave of absence which has not been approved by BP.

Publication date: April 2017

Beneficiary designation

When you enroll in the GUL, you should designate a beneficiary to receive any benefits that may be payable in the event of your death. You are automatically the beneficiary of any benefits payable due to the death of your covered spouse/domestic partner or child.

You can name one or more individuals, trusts or legal entities as your primary beneficiary. You can also name a secondary beneficiary, or contingent beneficiary.

If you name more than one primary or contingent beneficiary, you need to decide how benefits will be divided among them. If you die without having left instructions on how to divide the benefit, each beneficiary will receive an equal share. If a named beneficiary dies before you, his or her portion will be shared equally among any remaining beneficiaries, except to the extent otherwise provided on the applicable beneficiary form.

If you or your assignee (see Assignment of benefits) die before naming a beneficiary, or if no designated beneficiary is alive when you die, benefits will be paid as follows:

- To your spouse, if applicable.
- To your estate, if you have no spouse.

Making or changing your designation

You may name or change your beneficiary designation for GUL coverage at any time by logging on to the BP HR & Benefits Center via LifeBenefits at http://www.bp.com/lifebenefits. You may also contact the BP HR & Benefits Center by phone to make this update.

A beneficiary designation is not effective unless MetLife receives a completed form (submitted online or in paper format) before you die.

The identification of the proper beneficiary for the payment of your benefits will be made solely by MetLife.

Publication date: April 2017

Assignment of benefits

You may make a one-time assignment to transfer the ownership of your GUL benefit to a trust or to someone other than yourself.

To assign your GUL benefit, call MetLife to request an assignment form. MetLife will give you instructions for completing and returning the form. If you are married and live in a state with a community-property law, your spouse will have to sign a waiver allowing you to assign your benefits.

The assignment of your GUL benefit is effective the date MetLife approves your signed assignment form.

The trustee or the person to whom you have assigned your GUL benefit has the right to name a beneficiary to receive it in the event of his or her death. The assignee (trust or person) may name a beneficiary on your assignment form. If the assignee needs to make a subsequent change, he or she must call MetLife directly to request a beneficiary designation form.

Once you make the assignment, you cannot change or cancel it.

The trustee or the person to whom you have assigned your GUL benefit has the right to name a beneficiary to receive it. The assignee of the coverage can change the beneficiary of the assigned coverage by contacting MetLife to request a beneficiary designation form and returning the form to the address shown on the form.

Any assignments on file continue if benefits are ported. Otherwise, the assignment will expire.

Because assignments are generally made for tax reasons and are irrevocable, you should consult a qualified tax advisor before assigning your GUL benefit.

Publication date: April 2017

How the program works

Important information about the Group Universal Life Plan

The GUL Program allows you to purchase life insurance coverage for yourself and for your eligible dependents. The GUL Program pays benefits to:

- You, if your covered spouse/domestic partner or eligible child dies.
- Your beneficiary(ies), if you die.

The following GUL coverage options are available:

For you	One to eight times your base pay[1] — up to a maximum benefit of $7.5 million.	• You may be required to provide evidence of insurability acceptable to MetLife before coverage can begin. • Your GUL coverage will not be reduced if your base pay decreases for any reason while BP employs you.
For your spouse/ domestic partner[2]	Increments of $25,000 — up to a maximum benefit of $300,000.	• Regardless of whether you elect coverage for yourself, you may enroll for spouse/domestic partner coverage[3]. • You may be required to provide evidence of insurability acceptable to MetLife before coverage can begin. • Spouse/domestic partner GUL coverage is provided as a separate certificate and is owned by you. In the event of the termination of your marriage/domestic partnership or your death, your spouse/domestic partner may port GUL coverage. • Effective April 1, 2014, the calculation for spouse/domestic partner GUL coverage changed from one to four times your base pay to increments of $25,000. The coverage amount for your spouse/domestic partner was automatically increased to the next higher increment of $25,000 if the coverage was not already in a $25,000 increment.
For your eligible child (ren)	$10,000 for each eligible child	• If you elect GUL coverage for yourself and/or your spouse/domestic partner, you may also elect child coverage. • If both you and your spouse/domestic partner are BP employees, only one of you may cover your eligible children as dependents. • Once you elect this coverage, any future newborn child is automatically covered at 14 days of age. Any other newly acquired child (for example, through adoption or marriage) is covered as of the date he/she becomes your eligible child, unless evidence of insurability acceptable to MetLife is required before coverage can begin.

[1] If your base pay is not a whole multiple of $1,000, it will be rounded up to the next $1,000. If your base pay increases during the year, your GUL coverage amount automatically adjusts to reflect the increase. You must be actively at work for an increase to take effect. If you are not actively at work, the increase takes effect the day you return to active work status. You may elect to stop automatic coverage increases by calling the BP HR & Benefits Center. To reactivate automatic coverage increases based on your salary increase will require evidence of insurability.

[2] GUL coverage cannot be offered to domestic partners in some states. In addition, MetLife limits spouse/domestic partner coverage to no more than four times your base pay.

[3] Texas employees must elect coverage for themselves in order to cover a spouse/domestic partner.

Publication date: April 2017

Base pay

For purposes of the GUL Program, "base pay" means:

- For salaried employees, base pay is the base annual pay you receive each year.
- For hourly employees, base pay is your regular hourly rate multiplied by your regularly scheduled hours, projected over a 52-week period.

Unless an item of compensation is expressly included in this definition, it is not treated as base pay.

Note: Effective April 1, 2012, the calculation for employee GUL coverage changed from one to eight times your **eligible pay** to one to eight times your **base pay**, and the calculation for spouse/domestic partner GUL coverage changed from one to four times your **eligible pay** to one to four times your **base pay**. Your coverage amounts **were not** reduced if your new benefit calculations using base pay were less than your previous calculations using eligible pay.

Note: Effective April 1, 2014, the calculation for spouse/domestic partner GUL coverage changed from one to four times your base pay to increments of $25,000. Your spouse/domestic partner coverage was automatically increased to the next highest increment of $25,000 if the coverage was not already in a $25,000 increment.

Publication date: April 2017

Evidence of insurability

Evidence of insurability is a statement of health (proof of a person's physical condition) and/or other factual information that may be required for GUL coverage. To provide evidence of insurability for GUL coverage, log on to the BP HR & Benefits Center via LifeBenefits at http://www.bp.com/lifebenefits to complete a statement of health.

If you are newly eligible ...	**Coverage requested**		
Evidence of insurability requirements	**Employee**	**Spouse/ domestic partner**	**Eligible child(ren)**
None, if: • You enroll within your eligibility period.	1 to 5 x your base pay, up to $500,000	$25,000	$10,000
Required: • Complete a statement of health form.	1 to 5 x your base pay in excess of $500,000 6 to 8 x your base pay	Increments of $25,000 in excess of $25,000	N/A

If you enroll after your initial eligibility period or outside of 30 days from a qualifying status change, you will be required to provide evidence of insurability when you:

- Enroll yourself or your eligible dependents; or
- Increase coverage for yourself or your spouse/domestic partner.

If a special opportunity to increase GUL coverage is offered during Annual Enrollment, evidence of insurability may or may not be required as part of the opportunity.

Publication date: April 2017

Cash Accumulation Fund

The GUL Program allows you to set aside money through the Cash Accumulation Fund. If you enroll in the GUL Program, you may make contributions to the Cash Accumulation Fund through:

- Payroll deductions on an after-tax basis; or
- Additional lump-sum contributions.

Your spouse/domestic partner may also establish a Cash Accumulation Fund with lump-sum contributions.

The maximum amount you and your spouse/domestic partner may contribute to the Cash Accumulation Fund depends on your ages and coverage amounts. You can elect or change contribution amounts to the Cash Accumulation Fund for yourself or your spouse/domestic partner at any time. Call MetLife for more information.

Cash Accumulation Fund features include:

- **Guaranteed interest.** Your money grows at a guaranteed interest rate. The interest rate is set in December and may vary each year, but it will never be lower than 4%.
- **Tax-deferred interest.** The interest credited to your Cash Accumulation Fund is not subject to income tax while it remains in your account.
- **Pre-funded future insurance costs.** You can use your Cash Accumulation Fund to pre-fund insurance premiums after you leave BP.
- **Availability of funds when you need them.** You can withdraw money from your Cash Accumulation Fund at any time. The minimum withdrawal amount is $200; the maximum is your account balance.

You may also take out a loan against your Cash Accumulation Fund at any time. The minimum amount you may borrow is $200, and you may only have one loan outstanding per year. Loan repayments must be at least $100 per month and cannot be made through payroll deduction.

You should consult your financial advisor concerning any tax implications of any withdrawal from your Cash Accumulation Fund.

If you leave BP for any reason, including retirement, you can continue to contribute to the Cash Accumulation Fund, or you can choose to receive a lump-sum payment of the amount remaining in your account.

Your participation in the Cash Accumulation Fund ends when you reach age 100. If you have an account balance at that time, it will be paid to you in a lump sum.

Note: The Cash Accumulation Fund is not available to participants living in South Dakota, due to state laws. However, existing South Dakota residents who are participants in the Cash Accumulation Fund may be grandfathered.

Publication date: April 2017

Accelerated benefit option (ABO)

An accelerated benefit option (ABO) allows terminally ill participants the opportunity to receive up to 50% of their GUL benefit (subject to an 8% mortality and interest charge) during their lifetime. The minimum benefit available is $10,000 and the maximum benefit is $250,000.

An ABO is available to you or your spouse/domestic partner if:

- You or your spouse/domestic partner is covered by the GUL Program,
- You, your spouse/domestic partner or your legal representative requests payment of the ABO, and
- MetLife accepts the doctor's written certification that you or your spouse/domestic partner has a terminal illness and life expectancy is six months or less.

The ABO is payable only once, and payment is made only if the insured person is still living. Once an ABO is paid, the total GUL benefit is reduced by the amount received, and the cost for GUL coverage is adjusted to reflect this reduced benefit amount. Upon the covered person's death, the beneficiary will receive the remaining balance of the GUL benefit.

No ABO will be paid if:

- You have assigned your GUL insurance benefit.
- MetLife has been notified that all or a portion of your GUL insurance benefit is to be paid to your former spouse as part of a divorce agreement.
- Your life expectancy is limited and you are expected to die within six months as the result of:
    - Attempted suicide.
    - Injuring oneself on purpose.
- The amount of your GUL coverage is less than $10,000.
- A government agency requires you to request payment of an ABO before you may apply for, receive or keep a government benefit or entitlement, such as payment for long-term care in a skilled-nursing facility.
- You have elected to receive paid-up benefits.

You or your legal representative may request payment of an ABO by calling MetLife. A representative will outline the steps you or your legal representative must take to request the ABO.

Publication date: April 2017

Limitations and exclusions

The GUL death benefit will not be paid if death by suicide occurs within two years of the effective date of the GUL Program certificate. If this occurs, your beneficiary will receive an amount equal to all contributions paid for coverage less interest, minus any loan, loan interest or cash withdrawal.

Any increased portion of the death benefit will not be paid if death by suicide occurs within two years of the coverage increase.

Please note:

- Laws regarding coverage vary by state. See the policy or contact MetLife for detailed information on limits and exclusions.
- If you reside in Texas, spouse/domestic partner coverage is only available if the employee elects coverage for himself/herself. Additionally, coverage amounts for your spouse/domestic partner may not be more than the amount of coverage you elect for yourself.

Publication date: April 2017

How to file a claim

Claims should be filed with the claims administrator

To initiate the payment of benefits, you or your beneficiary should call the BP HR & Benefits Center. A representative will outline the steps you or the beneficiary must take to request benefits.

Request and payment of your GUL benefit

Benefit amounts will be paid to your beneficiary in a lump sum.

The request for benefits must be submitted to MetLife within 90 days of the death or as soon as reasonably possible. A certified copy of the death certificate or other written proof that is acceptable to MetLife must be included. Usually, MetLife will act on the request for benefits within 30 days. If more time is required, you or your beneficiary will receive written notification of the reasons for the delay.

Requesting an accelerated benefit option (ABO)

If you or your spouse/domestic partner has a terminal illness and a life expectancy of six months or less, you, your spouse/domestic partner or a legal representative may request payment of an ABO by calling MetLife. A representative will outline the steps to request the ABO.

Publication date: April 2017

If benefits are denied

If coverage for you, your spouse/domestic partner or your eligible child(ren) is denied due to evidence of insurability or insurance underwriting issues, MetLife will send you a notice of denial with the specific reason for the denial.

If you do not agree with MetLife's decision, you may file a written appeal, including supporting medical documentation, within 60 days from the date you receive the notice of denial. MetLife will respond to your appeal when the review process is completed. Send your appeal to:

MetLife
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512

You may discuss your appeal with MetLife by calling 1-800-638-6420 and selecting option 1.

You should receive a decision on your request for reconsideration within 30 days.

Publication date: April 2017

Process for formal claim for benefits

If you are not satisfied with a final benefits determination, you may file a formal claim. The formal claim must be in writing and must be filed with the claims administrator.

If the formal claim for plan benefits is denied, you will be provided with a notice of denial, which will contain:

- The specific reason for the denial.
- The specific reference to the plan provisions on which the denial is based.
- Descriptions of any additional information that is necessary to perfect the formal claim and an explanation of why this information is necessary.
- An explanation of the review procedure.

If your claim is denied in whole or in part, you will receive an adverse benefit determination within 90 days of the date your formal claim is received by the claims administrator unless special circumstances require an additional 90 days to process your claim. If an extension of time is required, you will be given written notice prior to the beginning of the extension period. The notice will indicate the special circumstances requiring an extension of time and the date by which the claims administrator expects the final decision to be rendered.

Process for formal appeals relating to claim denials

If your formal claim for benefits is denied in whole or in part, you may submit a written appeal of the decision to the same claims administrator within 60 days of the date you received the formal claims denial. In your written appeal, you may submit written comments, documents, records and other information relating to the claim, whether or not the materials or information was previously submitted in connection with the initial formal claim. You may also request that the claims administrator provide, free of charge, copies of all documents, records and relevant information relating to the claim.

You will be notified of the decision on appeal not later than 60 days after the appeal is received by the claims administrator. If an extension of time is needed (up to an additional 60 days) you will be given written notice before the beginning of the extension period. The notice will indicate the special circumstances requiring the extension of time and the date by which the claims administrator expects the final decision to be rendered.

The decision on your appeal will be in writing. It will include the reasons for the decision, a reference to the specific plan provision, as applicable, and other relevant information bearing on the decision. If you do not receive notice of the decision within 120 days after receipt of your appeal, it should be considered denied.

The decision on the appeal is final, conclusive and not subject to further review. The applicable claims administrator has full and exclusive authority to determine the eligibility of any individual to participate in the plan and receive plan benefits; and grant and deny claims under the plan, including the power to interpret the plan.

If following exhaustion of the plan's appeal procedure, you still believe that you are entitled to a benefit under the plan, you may file a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). You may not file a civil action less you have exhausted the plan's claims and appeals procedure.

Publication date: April 2017

Process for formal claims relating to eligibility to participate

You may make a verbal inquiry to the BP HR & Benefits Center if you have a claim related to such issues as:

- Eligibility to enroll in the plan;
- Enrollment elections; or
- Qualified status changes.

In many cases, the inquiry will resolve your issue.

If you believe that the response to your inquiry was based on inaccurate information or that additional information may clarify the issue, you may submit a written request for reconsideration to:

Claims and Appeals Management – BP
P.O. Box 1407
Lincolnshire, IL 60069-1407

You should receive a decision on your request for reconsideration within 30 days.

If you are not satisfied with the reconsideration decision, you may file a formal claim with the claims administrator by submitting a claim to the claims administrator in care of:

ERISA Claims and Appeals
P.O. Box 941644
Houston, TX 77094-8644

A formal claim related to eligibility cannot be filed with the claims administrator in care of ERISA Claims and Appeals until an inquiry and a request for reconsideration have been completed.

If you file a formal claim with ERISA Claims and Appeals on behalf of the claims administrator, it will be reviewed subject to the same timeframes applicable to formal claims for benefits. The review will be subject to the same procedures, protocols and standards.

If your claim is denied in whole or in part, you may appeal the adverse benefits determination by submitting an appeal to the claims administrator for appeals in care of ERISA Claims and Appeals. It will be reviewed subject to the same timeframes applicable to formal appeals for benefits. The review will be subject to the same procedures, protocols and standards.

If following exhaustion of the plan's appeal procedure, you still believe that you are entitled to either participate in the plan or to a benefit under the plan, you may file a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). You may not file a civil action unless you have exhausted the plan's claims and appeals procedure. However, any such suit must be filed with a federal court of proper jurisdiction located in Harris County, Texas, no later than one (1) year following a final denial pursuant to the plan's appeal procedure.

Publication date: April 2017

Leaving BP

What happens to benefits if you leave

Continuing coverage

For yourself

Your GUL coverage is portable. This means you can continue your coverage when you leave BP for any reason. You will also be able to continue your contributions to the Cash Accumulation Fund until you reach age 100.

After you leave the company, MetLife will automatically send you a packet that details what you need to do to continue coverage. You must respond within 31 days of receipt of the packet in order to continue coverage. Keep in mind that once you leave BP, billing frequency and rates charged may change.

If you **are** eligible* for retiree medical coverage when you leave, your premiums will be **not** the same as those paid by active BP employees or by terminated employees not eligible for retiree medical coverage. However, they are preferred group rates.

If you **are not** eligible* for retiree medical coverage when you leave, your premiums will be 20% higher than the premiums paid by active BP employees. When you reach age 70, your coverage is limited to five times the amount in your Cash Accumulation Fund or $20,000, whichever amount is higher.

* In general, you are eligible for coverage under the BP Retiree Medical Plan when you reach age 50 with at least 10 years of vesting service under a BP retirement plan, or age 55 with at least 5 years of vesting service under a BP retirement plan, and you are a full-time or part-time employee working for a BP employer group which offers its employees eligibility under the BP Retiree Medical Plan. For more details, refer to the Retiree Medical Plan summary under the "BP Medical Program" tab above, or contact the BP HR & Benefits Center to request a copy of the applicable BP Retiree Medical Plan summary plan description.

For your spouse/domestic partner

Your spouse/domestic partner can continue GUL coverage in the event of your termination of employment, your death or divorce or the dissolution of your domestic partnership by paying his/her premiums directly to MetLife.

If you are eligible* for retiree medical coverage at the time of your termination of employment, the premiums for coverage will **not** be the same as those paid by active BP employees. However, they are preferred group rates.

If you are not eligible* for retiree medical coverage at the time of your termination of employment, the premiums for coverage will be 20% higher than the premiums paid by active BP employees. When your spouse/domestic partner reaches age 70, his/her coverage is limited to five times the amount in his/her Cash Accumulation Fund or $20,000, whichever amount is higher.

Regardless of your retiree medical eligibility, the premiums that a spouse/domestic partner will pay for ported coverage following a divorce, dissolution of domestic partnership or death will be 20% higher than the premiums paid by active BP employees.

* In general, you are eligible for coverage under the BP Retiree Medical Plan when you reach age 50 with at least 10 years of vesting service under a BP retirement plan, or age 55 with at least 5 years of vesting service under a BP retirement plan, and you are a full-time or part-time employee working for a BP employer group which offers its employees eligibility under the BP Retiree Medical Plan. For more details, refer to the Retiree Medical Plan summary under the "BP Medical Program" tab above, or contact the BP HR & Benefits Center to request a copy of the applicable BP Retiree Medical Plan summary plan description.

For your children

Child coverage is a rider to the employee or spouse certificate. If the employee or spouse has portable coverage, then the child coverage is also billed directly at the participant's home. However, if a child reaches limiting age, then a conversion notice can be mailed upon request from the owner.

Converting coverage

You cannot convert your GUL coverage to individual coverage. However, if your covered child ceases to be an eligible dependent (e.g., he/she marries, exceeds age restriction, etc.) or if you die and have no spouse/domestic partner, your child may convert GUL coverage to an individual policy with MetLife within 31 days of the date his/her eligibility ends. Your child should call MetLife for details.

If you are rehired

If you ported your GUL coverage when you left BP and are later rehired, you may keep your ported coverage by continuing to pay MetLife directly. You may also elect new (additional) GUL coverage at employee rates. Because your new coverage will be treated as separate from your ported coverage, any prior beneficiary designation on file with MetLife with respect to the ported coverage will not apply to the newly elected GUL coverage. You must complete a new beneficiary designation form for any newly elected GUL coverage.

Publication date: April 2017

Administrative information

Detailed information about plan administration and your rights

Name of plan	BP Group Universal Life Plan, a component benefit program of the BP Corporation North America Inc. Consolidated Welfare Benefit Plan
Type of plan	Welfare benefit — insured.
Plan number	504
Plan year	April 1 – March 31
Plan sponsor and identification number	BP Corporation North America Inc. 501 Westlake Park Blvd. Houston, TX 77079 Employer ID#: 36-1812780
Plan administrator	Director, Health & Welfare BP Corporation North America Inc. 501 Westlake Park Blvd. Houston, TX 77079 1-800-890-4100
Sources of contributions	The BP Corporation North America Inc. Consolidated Welfare Benefit Plan is funded by participants' and participating employers' contributions and by investment earnings. Participant contributions are set by BP and may be adjusted from time to time. If participant contributions and investment earnings are insufficient to pay plan costs or expenses, the balance of the cost of the plan (if any) is paid by BP. Benefits may be paid through the BP Welfare Benefits Trust-III ("VEBA").
VEBA trustee	JPMorgan Chase Bank Worldwide Securities Services 4 New York Plaza New York, NY 10005
Claims administrator	MetLife Insurance Group Life Claims P.O. Box 3016 Utica, NY 13504 1-800-638-6420
Agent for service of legal process	For disputes arising from the plans, legal process may be served on: BP Legal BP Corporation North America Inc. P.O. Box 940669 Houston, TX 77094-7669 Legal process may be made upon the plan administrator.

Publication date: April 2017

Plan administrator

The plan administrator has the authority to control and manage the operation and administration of the plan. In this capacity, the plan administrator (or his/her authorized delegates) generally has several rights, powers and duties, including:

- Selecting and contracting with a claims administrator and other service providers.
- Determining expenses that can be paid from plan assets.
- Determining, in his/her discretion, whether an individual is eligible for or entitled to benefits.
- Interpreting plan provisions.
- Establishing rules and procedures for plan administration.

The plan administrator has designated MetLife to manage the day-to-day operations of the program, including processing and paying all claims for benefits.

In addition to the rights and duties described above, the plan administrator has the authority to:

- Refuse payment or reimbursement for claims incurred by any covered person or other person who has engaged in improper conduct with respect to the BP Corporation North America Inc. Consolidated Welfare Benefit Plan.
- Terminate a covered person's participation in the plan if he/she has engaged in improper conduct.

In order to determine whether a participant has engaged in improper conduct by covering an ineligible dependent, the plan administrator has the right to conduct internal or external audits of covered dependents at any time. In this regard, a participant may be asked to provide information and documentation supporting a covered dependent's status as an eligible dependent. Such documentation may include birth and marriage certificates, civil union or domestic partner registration materials, driver's licenses, passports, divorce decrees, court orders, tax records or other documents or materials supporting eligible dependent treatment. If selected for audit, the participant has the burden of establishing eligible dependent status to the satisfaction of the plan administrator. If a participant fails to respond timely to a request for information or materials, the plan administrator may take action, including but not limited to, increasing the participant's cost for dependent coverage or terminating the dependent's coverage.

Once it has been determined that an individual has engaged in improper conduct, the plan administrator has the authority to take any actions he/she deems appropriate to remedy such violations, including pursuing legal or equitable remedies to recoup any payments made by the BP Corporation North America Inc. Consolidated Welfare Benefit Plan to any party, regardless of when such improper conduct was taken or discovered. Such action will not preclude the company from taking other appropriate action.

If any individual loses any rights or coverage under the BP Corporation North America Inc. Consolidated Welfare Benefit Plan as a result of the plan administrator's determination of improper conduct, coverage will be retroactively terminated as of the date of the improper conduct.

Publication date: April 2017

Assignment of benefits and power of attorney (POA) matters

Assignment of benefits

You may make a one-time assignment to transfer the ownership of your benefit under the GUL Program to a trust or to someone other than yourself.

To assign your GUL coverage, you must do so in writing. To request an assignment form and instructions for completing and returning the form, call the BP HR & Benefits Center. If you are married and live in a state with a community property law (a law that states assets acquired during a marriage are equally shared by each spouse), your spouse must sign a waiver allowing you to assign your benefits.

The assignment of your GUL benefit is effective on the date MetLife approves your signed assignment form.

Once you make the assignment, you cannot change or cancel it.

The trustee or the person to whom you have assigned your GUL benefit has the right to name a beneficiary to receive it. The assignee of the coverage can change the beneficiary of the assigned coverage by contacting BP to request a beneficiary designation form and returning the form. Your GUL assignee may name a different beneficiary from the one named by you.

Any assignments on file expire when you leave BP.

Because assignments are generally made for tax reasons and are irrevocable, you should consult a qualified tax advisor before assigning your GUL benefit.

Power of attorney (POA)

Occasionally participants need assistance from a third party (agent) with benefits matters. If you wish to designate an agent to act on your behalf for your BP health and protection benefits, please contact the BP HR & Benefits Center for copies of the POA Notice (submission guide) for health and protection matters and related POA form or print copies from the LifeBenefits website Forms or Policies and programs links.

The POA Notice also explains the submission process for individually designated POAs, court orders and guardianships. Third parties may request a copy of the POA Notice by calling the BP HR & Benefits Center at 1-800-890-4100.

Please note that generally only one person or institution at a time can be recognized to act on behalf of a participant through submission of a POA, court order or guardianship. The BP HR & Benefits Center will not process a transaction if there is a reason to believe that the person making the transaction is not the plan participant, the participant's agent under a POA or court-appointed conservator or guardian.

An attorney in fact operating under a Power of Attorney may not change a participant's beneficiary designation.

Publication date: April 2017

Governing plan documents

In the preparation of this plan summary, effort was made to provide a clear, concise description of your benefits and to avoid contract and legal terms wherever possible. The aim has been to present a simplified overview of essential information about your benefits in words that are not obscure or likely to be misunderstood. As highlighted earlier in this summary, in the event of an inconsistency between this summary and the plan document (including insurance policies as applicable), the plan document will govern.

Employees covered by collective bargaining agreements are subject to this summary to the extent consistent with the terms of BP's benefit programs, the applicable collective bargaining agreement and any applicable legal guidelines.

Publication date: April 2017

No right to employment

Your eligibility for or your right to benefits under BP's benefit plans is not a guarantee of continued employment. BP's employment practices are determined without regard to the benefits offered as part of your total compensation package. In addition, and subject to legal and contractual considerations, BP reserves the right to terminate your employment at any time or for any reason.

Publication date: April 2017

Future of the plan

The company reserves the right to change or end a plan at any time without advance notice. The decision to do so may be the result of changes in federal or state laws governing benefits, or any other factor.

Publication date: April 2017

Your ERISA rights

As a participant in a BP benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants have the right to:

- Examine, without charge, at the plan administrator's office, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
- Obtain, upon written request to the BP HR & Benefits Center, copies of governing plan documents. A reasonable fee for copying may be assessed. The address used to request plan documents is:

  BP HR & Benefits Center
  P.O. Box 563944
  Charlotte, NC 28256-3944

  Participants may also download a copy of the summary plan description at no cost from the "Benefits handbook" tab on the LifeBenefits website at http://www.bp.com/lifebenefits.

- Receive a summary of the plan's annual financial report at no charge. Each participant is automatically provided with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your plans are called "fiduciaries" and have a duty to operate the plans prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or discriminate against you in any way to prevent you from obtaining benefits under the plan or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time limits.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court within Harris County, Texas. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless they were not sent because of reasons beyond the plan administrator's control.

The only proper venue for a lawsuit seeking enforcement of your rights under this plan is in federal court in Harris County, Texas.

If you have a claim for benefits that is denied or ignored, in whole or in part, or if you disagree with the plan's decision or lack thereof concerning the qualified status of a Domestic Relations Order (DRO), you may file suit in a state or federal court located in Harris County, Texas. (You can file suit only after you have exhausted the plan's claims and appeals procedures.) If the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court in Harris County, Texas.

The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose — for example, if the court finds your claim is frivolous — the court may order you to pay these costs and fees.

If you have any questions about your health and protection plans, you should contact the BP HR & Benefits Center.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or contact:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.

Washington, DC 20210

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APPENDIX B
INSURANCE CONTRACTS

Metropolitan Life
AND AFFILIATED COMPANIES

Metropolitan Life Insurance Company

A Mutual Company Incorporated in New York State

Policyholder: RHODE ISLAND HOSPITAL TRUST NATIONAL BANK, TRUSTEE

Group Policy No: A32900-G

Date of Issue: September 1, 1985

In return for the payment of the premiums when they fall due

Metropolitan Life Insurance Company
(Herein Called Metropolitan)

will pay the insurance and other benefits which are described in the Exhibits, subject to the terms and provisions of this Policy. The Schedule of Exhibits sets forth each Exhibit which is to be attached to and made a part of this Policy and to whom each such Exhibit applies.

Richard M. Blackwell
Vice-President and Secretary

John J. Creedon
President and Chief Executive Officer

Premiums Are To Be Paid On An Annual Basis

The Dividend, If Any, Is To Be Determined Each Year.